COMPLETING YOUR LIFE APPLICATION:

Use for Golden Promise ® Senior Whole Life.

You must submit:

- Application for Golden Promise ® (Form 4976-Rev.12/06.)

- HIPAA – Authorization For Release of Health Related Information (Form 5539-Rev.7/03)

Please be sure to read Golden Promise ® Telephone Verification at Point of Sale (Form 4994A) for information on completing telephone interviews.

You may also need the following forms:

- Modified Endowment Contract Disclosure (Form 5014) used with Golden Promise ® I Single-Pay applications only.

Submitting complete life applications with all the required forms will help us issue your business and pay your commissions more quickly. If you need assistance, please contact Marketing Services at 800-848-5433, ext. 4320.

Application For Life Insurance

SHENANDOAH LIFE INSURANCE COMPANY

1. PROPOSED INSURED INFORMATION

Last Name	First Name	MI	Phone Number for Contact
			Day

Social Security Number or Tax ID #	Sex	Date of Birth	State of Birth	Height	Weight	Evening / Best Time To Call

Primary Mailing Address	City	County	State	Zip Code

Mail Policy To: ..... ❑ Owner ❑ Agent/Producer

2. BENEFICIARY INFORMATION

Primary Beneficiary as to Proposed Insured, *with right of revocation*	Relationship	Telephone Number

Address of Primary Beneficiary	City	County	State	Zip Code

Contingent Beneficiary as to Proposed Insured, *with right of revocation*	Relationship	Telephone Number

Address of Contingent Beneficiary	City	County	State	Zip Code

3. OWNER *(if other than Proposed Insured)*

Last Name	First Name	MI	Social Security # or Tax ID #	Relationship to Proposed Insured

Street Address	City	County	State	Zip Code	Telephone Number

4. HEALTH INFORMATION (*circle any condition which applies*)

Provide details of all "Yes" answers on next page

Part A

1. Is the proposed insured currently: hospitalized, pending surgery or biopsy, bedridden, confined to a nursing facility, receiving Hospice or Home Health care, waiting for organ transplant, or confined to a wheelchair? ..... ❑ Yes ❑ No
2. Has the proposed insured ever had, been told they have, or been treated for:
   a. Alzheimer's disease, organic brain syndrome or dementia? ..... ❑ Yes ❑ No
   b. Acquired Immune Deficiency Syndrome (AIDS) or a positive test for HIV (Human Immunodeficiency Virus)? ..... ❑ Yes ❑ No
3. In the past 5 years, has the proposed insured had, been told they have, or been treated for: internal cancer, malignant melanoma or leukemia? ..... ❑ Yes ❑ No
4. In the past 12 months, has the proposed insured had, been diagnosed, or been told they have:
   a. Heart surgery to include heart bypass, angioplasty (balloon procedure), stent placement or heart valve replacement, heart attack, congestive heart failure, stroke, aneurysm, angina (chest pain) or kidney dialysis? ..... ❑ Yes ❑ No
   b. A drug or alcohol dependency/habit or treatment for alcoholism or drug addiction? ..... ❑ Yes ❑ No
5. In the past 12 months, has the proposed insured used or been told to use oxygen to assist in breathing? .... ❑ Yes ❑ No

Part B

1. Has the proposed insured ever had, been told they have, been treated for, or taken medication for:
   a. Chronic obstructive pulmonary disease (COPD) which includes emphysema, chronic asthma, chronic bronchitis, or any other chronic respiratory disorder? ..... ❑ Yes ❑ No
   b. Parkinson's disease, kidney disease, kidney failure, cirrhosis or other liver disease? ..... ❑ Yes ❑ No
2. In the past 2 years, has the proposed insured had, been told they have, been diagnosed or treated by a member of the medical profession, or taken medication for:
   a. Brain tumor, pacemaker, coronary artery disease, heart attack, heart surgery to include heart bypass, angioplasty (balloon procedure), stent placement or heart valve replacement, stroke, aneurysm, angina (chest pain) or any other heart or circulatory disorder? ..... ❑ Yes ❑ No
   b. Diabetes treated by insulin? ..... ❑ Yes ❑ No

COMMENTS ON ANSWERS TO MEDICAL QUESTIONS FROM SECTION 4

(Attach a separate sheet if more space is needed.)

5. INSURANCE APPLIED FOR

a. ❑ Golden Promise® I ..... ❑ Full Pay ❑ Single Premium ❑ 10-Pay
❑ Golden Promise® II

b. Face Amount ..... $_____ ❑ Smoker ❑ Non-Smoker

c. Have you smoked cigarettes in the past 12 months? ..... ❑ Yes ❑ No

6. RIDERS APPLIED FOR

❑ Accidental Death Benefit Rider ..... $_____ ❑ Other _____

❑ Nursing Home Waiver of Premium Rider
If applying for Nursing Home Waiver of Premium Rider, does the proposed insured require assistance from another person in bathing, dressing, eating or toileting? *(If yes, list details in Comments section above)* .... ❑ Yes ❑ No

7. PREMIUM AND BILLING INFORMATION

1. Premium Information:
   a. Premium ..... $_____
   b. Premium Mode *(excluding Single Premium)*
   NOTE: If you choose to pay your policy premium in semi-annual, quarterly or monthly payments, you will pay more over the year than if you choose to pay your premium in one annual premium payment.
   ❑ Monthly EFT ❑ Quarterly ❑ Semi-Annual ❑ Annual ❑ Other _____

2. a. Payment with Application ..... $_____
   b. Payment by credit or debit card *(credit/debit card payment not available for single premium purchase)* ..... $_____
   Cardholder Name _____
   ❑ Visa ❑ Mastercard Card Number _____ Expiration Date *(mm/yy)* ____/____
   CVV2 # *(Last 3 digits printed over signature on back of card)* ..... Not Applicable
   Billing address of Cardholder _____

   X _____ _____
   Authorized Signature of Cardholder Date

3. Premium notices sent to: ..... ❑ Proposed Insured ❑ Owner ❑ Other *(indicate below)*

Name	Relationship to Insured	Social Security # or Tax ID #

Address	City	State	Zip Code

4. Automatic Premium Loan ..... ❑ Yes ❑ No
I understand that by selecting this option a loan may be made against the cash value of my policy to pay premiums due.

8. FOR MONTHLY EFT PREMIUMS ONLY

I hereby authorize Shenandoah Life Insurance Company to make withdrawals each month from my account, indicated below, for the purpose of paying monthly premiums on any policy issued on this application.

CHECK ONE:

❑ Checking **For a Checking account, please attach a voided check.**

❑ Savings **For a Savings account, please complete the following information. Ask your financial institution to verify that this EFT will be accepted and that the information below is correct.** *This verification is necessary as not all financial institutions will acknowledge an EFT debit to a savings account.*

Financial Institution Name	Telephone Number	Transit Routing Number

Financial Institution Address

Depositor Address	Depositor Account Number

Please withdraw on the _____ day of each month (please choose a day between the 1st and the 28th). If a day is not selected, Shenandoah Life will select the day nearest the premium due date.

I agree that the withdrawals on this account and financial institution shall constitute due notice of premiums being due upon the policy. The withdrawals reflected on my account statement will constitute a receipt. This authorization is revocable only upon receipt by Shenandoah Life Insurance Company of a written notice of revocation. I understand that if any account withdrawal is not paid upon presentation and any premiums due on the policy are not paid within the time stipulated in the policy, insurance coverage may lapse or may be terminated by Shenandoah Life Insurance Company. A notification to stop EFT should be received by Shenandoah Life Insurance Company at least 5 days prior to the day of withdrawal.

X _____ _____ _____

Signature exactly as it appears on financial institution records | Print name of depositor, if other than proposed insured | Date

9. REPLACEMENT INFORMATION

a. Is there life insurance in force on the person proposed for coverage? ..... ❑ Yes ❑ No
If yes, list all life insurance coverage below.

b. Will insurance applied for replace any life insurance in force? ..... ❑ Yes ❑ No

c. Are any other applications pending with other companies? ..... ❑ Yes ❑ No

Insured's Name	Company	Owner	Replacement	Life Amount	Accidental Death Benefit	Year Issued
			❑ Yes ❑ No			
			❑ Yes ❑ No			
			❑ Yes ❑ No			

10. HOME OFFICE ENDORSEMENTS

SPECIAL REQUESTS

11. DECLARATIONS AND AUTHORIZATIONS

By this application, I am applying to Shenandoah Life Insurance Company ("SHENANDOAH") for a policy of life insurance. **I agree that:**

1. My statements and answers to the questions in this SHENANDOAH application are complete and true to the best of my knowledge and belief, and are the basis for issuing any policy.
2. **No insurance shall become effective unless a policy has been issued and delivered to me, the first premium paid and my insurability as stated in this application remains unchanged.**
3. Acceptance of any policy issued on this application shall constitute agreement to any correction or amendment of this application made by SHENANDOAH and noted on this application. However, no change in amount, age at issue, classification, plan of insurance or benefits applied for shall be made unless agreed to in writing by me.
4. No broker or agent has the authority to waive any of SHENANDOAH's rights or requirements, or to make or alter any contract or policy.
5. During the contestable period, SHENANDOAH has the right to rescind any policy issued upon statements or answers in this application that are not correct.

I authorize any medical professional, hospital, clinic, medical care institution, insurer or reinsurer, the Medical Information Bureau (MIB), consumer reporting agency, employer, relative, friend or neighbor to disclose to SHENANDOAH, its reinsurers, and, except for the Medical Information Bureau, any consumer reporting agency acting on behalf of SHENANDOAH, medical and other information pertaining to me. The information that may be disclosed includes information relating to employment; other insurance coverage; past and present physical, mental, drug and/or alcohol conditions; character; habits; avocations; finances; general reputation; credit or other personal characteristics.

I understand that SHENANDOAH may collect information for the purpose of determining eligibility for insurance. I agree that this authorization will be valid for two and one-half years from the date it is signed. I know that I or my authorized representative have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

DISCLOSURE OF GRADED DEATH BENEFIT: The coverage you receive may contain a graded death benefit, which means that, after evaluating your application, SHENANDOAH may issue you a policy that provides for either:

1. A full death benefit. The benefit is <u>not</u> reduced for a death occurring in the early years of the policy; or
2. A reduced death benefit for a nonaccidental death occurring during the first three policy years. The death benefit in the first policy year will be 25% of the full death benefit; in the second policy year it will be 50% of the full death benefit; and in the third policy year it will be 75% of the full death benefit. After the third policy year, the full death benefit is paid. (There is no reduction in benefit for accidental death.)

Any person who, knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Note: The following state requires that an alternate statement regarding insurance fraud be given. If you are a resident of the following state, please consider the following statement as a replacement for the above statement.

<u>Tennessee</u> **– It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.**

I acknowledge that I have received the Investigative Consumer Report Notice and Medical Information Bureau Disclosure Notice attached to this application.

Signed at _____ on _____
City, State Date

X _____ **X** _____
Signature of **Proposed Insured** Signature of **Owner**, if other than Proposed Insured

12. AGENT CERTIFICATION

To be completed by agent. I certify that I have asked the persons proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

Do you have knowledge or reason to believe that this application replaces existing life insurance? ..... ❑ Yes ❑ No

Print Agent's Name	Agent's Code	Telephone Number	**X** Agent's Signature
Print Agent's Name	Agent's Code	Telephone Number	**X** Agent's Signature

SHENANDOAH LIFE INSURANCE COMPANY

CONDITIONAL RECEIPT (Please detach and leave with applicant if payment is accepted with application)

Prior to the delivery of the policy, coverage will be effective only when ALL of the following conditions are met:

a) The full first premium according to the mode of payment specified in the said application has been tendered and honored for payment when presented;

b) A later date is not requested in the application;

c) The Proposed Insured is on that date an acceptable risk under the Company's rules, limits and standards as to plan, benefits, class, and amount for the policy applied for; and

d) There is no material misrepresentation in the application furnished to the Company.

Subject to satisfactory completion of all of the above conditions, coverage under this receipt will begin on the date the application is signed.

The maximum death benefit and all other supplemental benefits provided by this receipt will be the lesser of a) the total death benefit payable under the policy(ies), including any Accidental Death Benefit, on all pending applications with the Company or b) $250,000.

If any condition under this receipt is not met, the Company's only liability will be to refund the premium payment. Either the Company or the proposed owner may terminate coverage under this receipt by notice to the other. In no event will coverage under this receipt be in force after 60 days from the date of the application.

No broker, agent or medical examiner may waive a complete answer to any question in the application, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements.

If there is material misrepresentation in the application (or in any medical information furnished to the Company), the Company's only liability will be limited to refunding the premium payment.

If the proposed insured commits suicide, whether sane or insane, the Company's only liability will be limited to refunding the premium payment.

If any question in Part A of the application has been answered YES, no payment may be accepted with this application.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO SHENANDOAH LIFE INSURANCE COMPANY.
NO PREMIUM CHECKS SHOULD BE PAYABLE TO ANY AGENT OR A BLANK PAYEE.

Received $_____ from _____ for an application on _____ dated _____.

X_____ X_____

Signature of **Owner** Signature of **Agent**

AUTOMATIC PAYMENT AUTHORIZATION (Please detach and leave with applicant)

As a convenience to me, I request and authorize you, until revoked by written notice, to initiate debit entries (charges), electronically, by paper means or by any other commercially accepted method, to my account for payment of premiums, provided there are sufficient funds in my account to pay the debits. I understand this authorization is applicable only if requested on my application.

MEDICAL INFORMATION BUREAU PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. Shenandoah Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Shenandoah Life Insurance Company or its reinsurers may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
2. Such information, as well as other personal or privileged information subsequently collected, may be disclosed to third parties in certain circumstances, without authorization.
3. A right of access and correction exists with respect to all personal information collected.
4. A more complete notice describing our information practices in detail will be furnished to you upon request.

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION

As part of our procedure for processing your initial application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon furnishing proper identification, you have the right to make a written request within a reasonable period of time to inspect and/or receive a copy of the report and/or to receive additional, detailed information about the nature and scope of this investigation. For this information you may write to the Underwriting Department, Shenandoah Life Insurance Company, P.O. Box 12847, Roanoke, Virginia 24029. This notice is in compliance with the Fair Credit Reporting Act (Public Law 91-508).

Note: Within 60 days of the date of this application you will be notified as to whether or not this application has been accepted or else be given the reason for any further delay.

SHENANDOAH LIFE INSURANCE COMPANY

GOLDEN PROMISE®
TELEPHONE VERIFICATION
AT POINT OF SALE

Call

1-800-308-0056

or

Fax a Request

1-540-857-5925

or

E-mail a Request

telephone.interview@shenlife.com

see attached bulletin for details!

SHENANDOAH LIFE INSURANCE COMPANY

GOLDEN PROMISE® TELEPHONE VERIFICATION AT POINT OF SALE

As you know, Golden Promise® is underwritten based solely on a telephone verification of the questions on the application and an inquiry to the Medical Information Bureau (MIB). In order to simplify the telephone verification process, you can call and set up the telephone interview at your client's convenience, even at the time of sale.

Simply call 1-800-308-0056

Identify yourself as an agent of Shenandoah Life who would like to have a Golden Promise® telephone interview completed. The interviewer will obtain the applicant's identifying information such as name, address, plan applied for, etc., from you. The interviewer will then complete the verification of the medical questions on the application with the applicant.

The entire process should take no longer than 5 to 7 minutes. Calls can be taken from 9:00 a.m. to 9:00 p.m., EST, Monday through Friday. In addition, calls can be taken from 11:00 a.m. until 3:00 p.m. on Saturdays. Outgoing calls to your clients will not be made after 9:00 p.m. in any time zone. (Note: Telephone interviews can be conducted during the hours listed.)

You can also order a telephone interview 24 hours, 7 days a week using any of the following methods:

- Leave a voice mail message request using 1-800-308-0056.
- Fax a completed GP telephone interview request form (Form 5015-Rev. 1/05) to 540-857-5925.
- E-mail your request to telephone.interview@shenlife.com.

We encourage you to take advantage of this convenience whenever possible. Since the home office completes the interview, it will be here waiting to be matched with the application as soon as we receive it. This enables us to provide faster approval and payment of commissions on your business!

Please note, the applicant must always complete the telephone interview without assistance from the agent or another person. All agents should, of course, follow the normal procedure of calling the toll-free number to set up the interview, but no one other than the applicant can participate in the telephone interview process, either as an interpreter or as an aid to the applicant. This provision applies to all telephone interviews.

In limited instances, exceptions to this guideline will be made. Requests for such exceptions must be made to the home office prior to the actual telephone interview. If the applicant is unable to complete the telephone interview, and an exception has not been granted in advance by the home office, the application will be returned.

We are pleased to provide this point of sale telephone interview service to you, and hope this assists you in your Golden Promise® sales.

SHENANDOAH LIFE INSURANCE COMPANY

MODIFIED ENDOWMENT CONTRACT DISCLOSURE

The Technical and Miscellaneous Revenue Act (TAMRA) that was signed into law November 10, 1988 alters the tax treatment of distributions from certain types of life insurance policies. The law applies to all policies issued or materially changed on or after June 21, 1988.

If premiums paid on such a policy are in excess of the limits established by Congress, then the policy is classified as a Modified Endowment Contract (MEC). If there is gain in the contract, the portion of the gain included in any distribution, including policy loans, will be reported as taxable income. If a distribution occurs prior to the insured attaining age 59½, the taxable portion of the distribution may also be subject to a 10% tax penalty.

A policy that, at issue is, or later becomes a Modified Endowment Contract will always be subject to MEC tax treatment. This applies even if the policy is exchanged for a new contract that, standing alone, would not be a MEC.

Tax-deferred growth in cash values and tax-free death benefits are still available under a MEC.*

I have read the above and understand that the policy for which I am applying will be a Modified Endowment Contract.

_____ X_____

Name of **Owner** (Please Print) Signature of **Owner**, or Parent/Guardian, if applicable

_____

Date

* *If legal advice or other expert assistance is required, the services of a competent professional should be sought. Shenandoah Life gives neither legal nor tax advice. The information provided is intended to be accurate based on Shenandoah Life's understanding and interpretation of current tax laws, which are subject to change.*

SHENANDOAH LIFE INSURANCE COMPANY

INDIVIDUAL UNDERWRITING

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO SHENANDOAH LIFE INSURANCE COMPANY

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services on my behalf within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning me to Shenandoah Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Shenandoah Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage that I have applied for with Shenandoah Life Insurance Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that if I reside in Kansas, Kentucky, New Mexico, or Oklahoma, this Authorization shall remain valid for 24 months; and for 26 months if I reside in Minnesota; and, if I reside in Arizona as to HIV-related information only this Authorization shall remain valid for 180 days. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Shenandoah Life Insurance Company at P.O. Box 12847, Roanoke, VA 24029, Attention: Chief Privacy Official. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Shenandoah Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record, Shenandoah Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

_____ _____

Name of Proposed Insured (please print) Date

X_____

Signature of Proposed Insured

_____ _____

Name of Proposed Insured (please print) Date of Birth

TO BE COMPLETED BY AGENT OR HOME OFFICE ONLY